Welcome!

Welcome to the VA National Center for Patient Safety's new newsletter — NCPS TIPS! As you can tell from our nameplate, TIPS is an acronym for "Topics In Patient Safety." Our objective with this publication is to bring you useful and timely topics concerning patient safety.

For NCPS TIPS to be successful we're asking for your help in giving us feedback. Please contact us with any questions, comments or articles you would like included in future issues. Phone us at (734) 930-5890 or e-mail us at ncpstips@med.va.gov.

Your feedback is very important to us -- keep those cards and letters coming!

What's Inside

VA & NASA

"Partners for Safety"

As many of you know, VA formed an agreement with NASA last May to develop a Patient Safety Reporting System (PSRS) for the VA. This system's guiding principles are voluntary participation, confidentiality protection, and non-punitive reporting and is designed to be a complementary external system to our current internal reporting system.

NCPS and NASA have been steadily working on the design and development of this system and we are set to begin pilot testing PSRS early this year at a few VA medical centers. We plan to have the entire system running by the beginning of FY2002.

NASA is using its experience from developing and running its highly successful Aviation Safety Reporting System (ASRS). NASA developed and has been running this system for the Federal Aviation Administration since 1976. ASRS has been lauded for its strict confidentiality procedures, managed reports, database created for the easy retrieval of information, creation of safety products and distribution of safety information. Their knowledge and experience in this area will be applied to PSRS.

Please remember that PSRS **does not** replace our current internal reporting system. As was stated earlier, PSRS is designed to be a *complementary* system to our internal reporting system. PSRS will identify vulnerabilities, but not provide detailed solutions as is the case with events that are reported internally and subjected to our Root Cause Analysis system.

Patient Safety Alerts

To check out the latest VHA Patient Safety Alerts visit http://vaww.ncps.med.va.gov/alerts.html.

Facility Feedback

(Patient safety feedback from throughout the VHA. Please send any comments you'd like to share with us to ncpstips@med.va.gov.)

IG Visit

We recently had a visit from the IG (they had 23 on-site) that went very well. The IG staff were aware of the RCA process, and were very impressed with the actual implementation at our medical center. They requested RCAs in advance and also reviewed them on site. They commended the work that had been done and spoke very highly of the process. The IG wanted proof that there had been follow up from the action items and asked to see measures associated with the RCAs, which we were able to show them.

--Carol Biggs
South Texas VHCS

Joint RCA

We are incorporating an aggregate RCA into a joint process action team (PAT) with our staff and staff from Tripler Army Medical Center (TAMC), with whom we have a sharing agreement. We have identified skin breakdown issues with patients transferring between our Center for Aging and Tripler's inpatient med/surg. units ... Our COS, Director, and myself felt it was necessary to have people from Tripler help us address these issues through a PAT. The charter memo states the following: 1) conduct an aggregate RCA on 6 current TAMC/ VA cases that have resulted in negative outcomes related to skin breakdown; 2) from this review, develop/implement a uniform assessment and documentation process to be applied throughout the federal medical campus; 3) implement practice guidelines related to the prevention and management of skin ulcerations; 4) develop a conjoint review process to assure that reviews are occurring when relevant; and 5) describe the review process, aggregation of data and reporting mechanisms. Getting the joint team together, at the same time as trying to promote a non-punitive culture has been very challenging, but has finally happened. The team convened recently and JIT training has taken place.

We also just completed a CARF survey for some of our mental health programs. The CARF surveyors were briefed on the RCA process and given some examples of how it has been implemented within the facility. The CARF team complimented us on having an exemplary integrated risk management program with great emphasis on patient safety and improvement activities.

--Cheryl Taylor
Honolulu VAMROC

Notes from the NCPS staff

The Grapevine

• Many facilities are not meeting the 45 day RCA completion time frame. In many cases this is due to the large number of individuals involved in the review and approval of the Charter Memo and the RCA report. On the front end when issuing the Charter Memo it is critical that supervisors of the respective team members be consulted. However, to facilitate the process, we recommend that this be done informally using the telephone or electronic mail. Having each supervisor individually review and concur with the Charter Memo builds in unnecessary delay.

Only the team members, advisor, and Director (or equivalent) need be involved in the RCA report signature process. While we strongly encourage advisors to have RCA teams consult with those individuals tasked in Table 19 with completing the actions, a formal signature process impedes completing the report. Remember that no one, with the exception of the Director, has veto authority over the team's recommendations. The important point is to get the report completed and the recommendations implemented as soon as possible to prevent the adverse event from recurring. Please review and streamline your process.

• Facilities are returning RCA reports to RCA teams for correction of *typograficla* errors or to enhance the appearance of the flow charts. This is NOT necessary! We in NCPS are concerned with the content of the report, not its appearance. The important point is to implement the actions.

SAFETY SPOTLIGHT

(On a regular basis we will feature teaching examples pulled from medical literature and similar RCAs that we feel are applicable and of interest to the entire VHA healthcare system. These cases are intended to be used for learning purposes only.)

Description

A patient was being prepared for a CT scan in a busy, noisy, crowded room. The telephone was ringing, multiple staff were present, and the scans were running behind schedule. Patients were doubled up in the preparation room, in an attempt to speed up the process and to address the backlog. Two CT techs were sharing the duties of preparing the patients, moving as fast as they could so as not to slow down the process.

One of the CT techs took the next patient and prepared to use the power injector to inject contrast prior to the CT. Tech #2 arrived after Tech #1 had left for another area. Seeing the syringe plunger extended and the chamber nose down, he assumed that the power injector had been reloaded. Tech #2 proceeded with the scan, injecting approximately 150 ml of air into the patient. Initially the clinical staff assumed the problem was anaphylaxis. Further review identified the true problem and appropriate actions were taken. The patient survived with no permanent adverse outcome.

Vulnerabilities

In this instance there were numerous vulnerabilities and system weaknessses present:

■ The design of this equipment lends itself to such errors.

■ There is no lockout device preventing using the machine without a full syringe.

■ In addition, the design of the prep room contributed to an environment conducive to error, as was the pressure to expedite the scans.

■ Finally, the division of duties between the two techs led to a potential to fail to communicate about the status of the patients and their procedures.

Actions Taken

In response to this case, the facility took the following actions:

■ Developed interim plan to reduce traffic and phone calls in the CT control room.

■ Addressed work volume and staffing issues.

■ Educated staff on signs and symptoms of air emboli.

■ Investigated the availability of alternative equipment with lock out features.

■ Identified and ultimately purchased power injector with lock-out feature preventing air injection.

Conference Calendar

CONFERENCE	DATE	LOCATION
DCAHQ "The Impact of Regulatory & Voluntary Compliance"	4/6/01	Washington, DC
NCPS Patient Safety Improvement Training	4/24-26/01	TBD
VHA Nat'l Quality/Safety Conference	5/1-4/01	New Orleans, LA
NCPS Patient Safety Improvement Training	6/5-7/01	TBD
NCPS Patient Safety Improvement Training	9/11-13/01	TBD

NCPS Rolls Out Improved Software

NCPS will soon be implementing improved software for the RCA process and patient activities. The software, called SPOT, is now being used and evaluated in Florida VAMCs. We will be refining training materials, improving design, and finding/fixing any incompatibilities.

We anticipate that in the next several weeks these issues will be addressed and we will begin roll out to other networks. In general, we will be installing (rolling out) the patient safety software in the same sequence as the networks were trained last year.

The new software will have many new and useful functions. RCA cases will now be sent securely, electroni-

Learning Links

Each issue we'll try to highlight a web site that we think is informative and innovative.

This issue's site is "Bad Human Factors Designs" at **www.baddesigns.com**. It is a scrapbook of illustrated examples of things that are hard to use because they do not follow human factors principles.

Check it out and let us know of any web sites that you think we should include in future issues.

cally, and nearly immediately. Flowcharts can be automatically drawn and edited from text outlines. Previous RCA cases can be searched. Finally, on-line help and automation is built into the RCA data entry.

Salt Lake City Starts Rewards Program

The Salt Lake City VAMC has initiated several actions that substantially and positively impact the patient safety program within their facility. Team members on RCAs receive letters signed by the Facility Director and the Chief of Staff congratulating their involvement and outlining the actions that will be taken based on the RCA recommendations, as well as a special contribution award.

They have taken the incentive program a step further so that anyone who reports an adverse event that is then the basis for an RCA also receives a special contribution award of $100. At the close of the RCA, the person who reported the incident also receives a letter of thanks from the Patient Safety Improvement Coordinator outlining the corrective actions that

will be taken. Pamela Bennett, Patient Safety Improvement Coordinator, and Valerie Robinson, Quality Management Director, initiated and coordinate this new rewards program.

In the vein of the learning organization, SLC staff seek out feedback and suggestions for improvement from each team member after each RCA through a simple survey (see our website for example of the survey). The results?

■ 100% strongly agree the RCA process was valuable and time allocated sufficient.

■ 100% strongly agree or agree that able to identify root causes/contributing factors for event, able to develop meaningful recommendations, found participation in the RCA process valuable, and felt the team worked efficiently.